Default Question Block

Select the organization/contract for which you are filling this form out.

- ○ ADDS
- ○ CFR
- ○ UIowa North
- ○ UIowa South
- ○ UCS

Select the Semi-Annual report for which this form is being filled.

- ○ September 2020 - February 2021
- ○ March 2021- August 2021

How many SOR CL admissions (completed GPRA intake) did your organization complete this quarter?

Select all MAT services that were offered on-site by your organization (not subcontracted to UCS or other OTP) this quarter.

- ☐ MAT Medical Care
- ☐ MAT Medical Evaluation
- ☐ MAT Medication
- ☐ Not applicable

Select all MAT services that were offered by a partnering organization this quarter.

- ☐ MAT Medical Care
- ☐ MAT Medical Evaluation
- ☐ MAT Medication
- ☐ Not applicable

Select all Recovery Support Services (RSS) your clients received from SOR CL in this quarter.

- [ ] Co-Pays
- [ ] Dental Services
- [ ] Drug Testing
- [ ] HIV & Viral Hepatitis Testing
- [ ] Housing Assistance
- [ ] Recovery Calls
- [ ] Recovery Peer Coaching
- [ ] Supplemental Needs- Clothing/Personal Hygiene Products
- [ ] Supplemental Needs- Education
- [ ] Supplemental Needs- Transportation: Bus
- [ ] Supplemental Needs- Transportation: Gas Cards / Cab / Ride Sharing Apps
- [ ] Supplemental Needs- Utility Assistance
- [ ] Supplemental Needs- Wellness

If you did **not** select a RSS in the previous question, explain why that service(s) was not provided to SOR CL clients this quarter.

How many **Naloxone Kits** have you distributed to the following populations within this quarter? If none, please type 0.

	Number of Naloxone Kits
First Responders	
Client and Client's family/friends	
Community Service Organizations	
Other (please describe)	

How many trainings did your organization provide on **Opioids and Prescribing Guidelines** within this quarter?

Number of Trainings

	Number of Trainings
Primary Health Care Providers (physicians, nurses, PA's, .etc)	
Behavioral Health Care Providers (counselors, prevention staff, peer support coaches, etc.)	
First Responders	
Other (please describe)	

To whom have you provided trainings on **MAT** within this quarter, and for how many? (estimate to the best of your ability)

	Number of Trainings
Primary Health Care Providers (physicians, nurses, PA's, .etc)	
Behavioral Health Care Providers (counselors, prevention staff, peer support coaches, etc.)	
First Responders	
Other (please describe)	

To whom have you provided trainings on **Naloxone/Opioid Poisoning (Overdose) Prevention** within this quarter, and for how many?

	Number of Trainings
Primary Health Care Providers (physicians, nurses, PA's, .etc)	
Behavioral Health Care Providers (counselors, prevention staff, peer support coaches, etc.)	
First Responders	
Other (please describe)	

Please decribe your collaboration with local or regional correctional staff and/or facilities.

Please describe the developement and engagement of the community stakeholder group within this quarter.

Please describe the community stakeholder group's efforts in identifying solutions to barriers for formally and currently incarcerated people with substance use disorders during community re-entry within this quarter.

I confirm that I will submit a correspondance in IowaGrants stating I have completed the quarterly report.

- ○ Yes